

**STATEMENT OF  
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THE AMERICAN LEGION  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
ON  
REPORT OF THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE  
DELIVERY FOR OUR NATION'S VETERANS**

**JUNE 17, 2003**

Mr. Chairman and Members of the Committee, The American Legion would like to take this opportunity to publicly thank the Commission Members of the President's Task Force (PTF) for their time, energy, effort, and cooperation throughout this process. I would also be remiss if I failed to applaud the PTF's professional staff for an exceptional performance. From the very first day, the professional staff established an unprecedented working relationship with the entire veterans' community. Although not recognized in the Report's bibliography, attached to this testimony are samples of the material provided to the PTF's professional staff by The American Legion. All material was readily accepted, but closely scrutinized by Commission Members. This included information gathered during a visit with the Indian Health Services in Albuquerque, NM to learn more about their successful billing and collection practices of third-party insurers, to include Medicare and Medicaid. Although Members of the PTF made two separate trips to Albuquerque to visit the New Mexico VA Health Care System and 377<sup>th</sup> Air Force Medical Group, Kirtland AFB, New Mexico, they never visited the Indian Health Services located just blocks away.

The American Legion continues to work closely with the Department of Veterans Affairs (VA), the Department of Defense (DOD), and Congress towards a mutual goal – meeting the needs of America's veterans and their families. Although this is a shared objective, each seems to have its own "road map" for achieving that vision. Frequently, compromise is reached and life is made just a little better for veterans and their families, but unfortunately there is still rough terrain to traverse to improve health care delivery for the Nation's veterans.

Executive Order 13214's mandates were clear:

- *Identify ways to improve benefits and services for the Department of Veterans Affairs beneficiaries and Department of Defense military retirees who are also eligible for benefits from the Department of Veterans Affairs through better coordination of the activities of the two Departments;*
- *Review barriers and challenges that impede Department of Veterans Affairs and Department of Defense coordination, including budgetary processes, timely billing, cost accounting, information technology, and reimbursement. Identify opportunities to improve such business practices to ensure high-quality and cost-effective health care; and*
- *Identify opportunities for improved resource utilization through partnership between the Department of Veterans Affairs and the Department of Defense to maximize the use of*

*resources and infrastructure, including buildings, information technology and data sharing systems, procurement of supplies, equipment and services, and delivery of care.*

Clearly, The American Legion embraces these mandates. Long before President Bush created this bold initiative, The American Legion developed an internal task force with a simple mandate – design an integrated health care delivery system to meet the needs of all veterans and their families.

### **G.I. Bill of Health**

Over a decade ago, The American Legion offered its blueprint for VA in the 21<sup>st</sup> Century called the G.I. Bill of Health. The vision was to create a national integrated veterans' health care network accessible by all veterans and their dependents, including military retirees and their eligible family members. This bold plan called for Congress, beneficiaries, and third-party insurance providers to meet their respective fiscal obligations.

#### *Federal Government Pays Only One Veterans' Health Care Delivery System*

The first step called for enrollment of all beneficiaries seeking enrollment in the Veterans Health Administration (VHA). Enrollment would provide the VA Secretary with a quantified and defined patient population. Once enrolled, each beneficiary would identify how his or her health care coverage would be paid. If a beneficiary was eligible for full health care coverage paid for by just the Federal government (Medicare-eligible, 100 percent service-connected disabled veteran or military retiree), Congress would appropriate funds to cover that cost. However, if the beneficiary was eligible for full health care coverage paid by several Federal agencies (a Medicare-eligible, 100 percent service-connected disabled veteran, and a military retiree), Congress would make only one payment; however, the beneficiary would seek health care only within VHA unless referred to the private sector for care. Medicare-eligible veterans choosing this option would be authorized to seek health care only from within VHA medical facilities (Medicare+Choice model).

#### *Third-Party Reimbursements Contribute to the Costs*

Those beneficiaries choosing to enroll, with private or public health benefit coverage, would identify their third-party insurance provider and would agree to meet all co-payments and deductibles described by their policy. Should the third-party insurer refuse to make reimbursements to VA for the treatment of nonservice-connected medical conditions, the beneficiary would be denied enrollment.

#### *Uninsured Beneficiaries have Affordable Options*

For those beneficiaries choosing to enroll with no health benefit coverage, VA would be authorized to offer affordable health benefit packages to meet their individual health care needs. The Secretary would establish the premiums for each health benefit package and could waiver premiums on a case-by-case basis.

For those beneficiaries identified in title 38, United States Code (USC), for the VA Secretary to provide care, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. For those beneficiaries identified by the DOD Secretary to receive care, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. For those Medicare-eligible beneficiaries, Congress would appropriate funds to cover the cost of the required health benefit coverage necessary, based on their individual health care needs. All other beneficiaries would be responsible for meeting their health care needs through co-payments, deductibles, premiums, or third-party reimbursements from public or private insurance providers. All revenue streams (Federal appropriations, co-payments, deductibles, premiums, and third-party reimbursements) would go to a Veterans Health Trust Fund, similar to the Social Security and Medicare Trust Funds.

## **TRICARE**

At the time as The American Legion was developing its G.I. Bill of Health, DOD's military health care system was experiencing tremendous problems in meeting its commitment to its beneficiaries, especially its large military retirement community. The cost of providing health care to all of its beneficiaries grew tremendously which forced many of its patients to "game" the system in order to receive timely access to health care.

### *Shared Cost of Health Care*

DOD's solution was the creation of TRICARE – a unique quasi-governmental health care network consisting of the military health care system and private contractors. Under TRICARE, active-duty service members and their eligible beneficiaries receive health care coverage paid for by DOD; however, all other beneficiaries have four health care options to choose from that also require out-of-pocket costs:

- TRICARE Standard (fee-for-service – co-payments and deductibles)
- TRICARE Extra (preferred provider organization – co-payments and deductibles)
- TRICARE Prime (health maintenance organization – enrollment fee and co-payments)
- TRICARE for Life (Medicare+Choice option – must have Part B coverage and stay within the system)

## **President's Task Force To Improve Health Care Delivery For Our Nation's Veterans**

The PTF's challenge was clear from the very beginning. Although VA and DOD are committed to the timely delivery of quality health care, each health care network is truly distinctive in its leadership structure, operational mandates, information technologies, procurement systems, and are equally committed to meeting their unique missions. Nearly all of the witnesses testifying before the PTF from the veterans' community shared the same key message point – maintain each health care delivery system as an independent entity – don't try to consolidate into one Federal health care delivery network. All Commission Members unanimously agreed to the following recommendations, with the exception of **Recommendation 5.3**.

## **Introduction and Background**

**Recommendation 1.1:** *The interagency leadership committee should, on an annual basis, report to the Secretaries on the status of implementing its collaboration and sharing initiatives and the recommendations in this Final Report, together with any other matters that the committee deems appropriate. Within 60 days after receipt, the Secretaries shall transmit the report, together with any related comments, to the President.*

The American Legion sees merit to this recommendation. Suggested collaboration and sharing initiatives should be formally recognized and monitored for desired results. However, those recommendations not accomplished should also be recognized and monitored to determine the obstacles prohibiting collaboration and sharing initiatives.

### **The Need for Leadership, Collaboration, and Oversight**

**Recommendation 2.1:** *Congress should amend the fiscal year 2003 National Defense Authorization Act to create a broader charter beyond health care for the interagency leadership committee. Additionally, consideration should be given to using civilian experts as consultants to the committee to bring in new perspectives regarding collaboration and sharing.*

The American Legion strongly agrees with the first part of this recommendation calling for a broader charter. This Committee and the Committee on Armed Services should provide timely oversight to monitor the focused commitment and leadership to achieve effective collaboration and sharing. The American Legion noted greater collaboration and sharing at the joint operations hosted by VA rather than DOD. With current discussion of another round of base closings, there well may be opportunities for collaboration and sharing initiatives, especially if DOD decides to close yet more Military Treatment Facilities (MTFs).

The American Legion **disagrees** with the second part of this recommendation to hire civilian experts as consultants to the committee. Both agencies employ resourceful, professional health care administrators. Given encouragement and motivation by the senior leadership to unleash their creative juices, these current employees will produce positive results.

**Recommendation 2.2:** *The Departments should consistently utilize a joint strategic planning and budgeting process for collaboration and sharing to institutionalize the development of joint objectives, strategies, and best practices, also with accountability for outcome.*

The American Legion agrees with this recommendation. By placing this requirement in performance standards for each Department's strategic planners and budgeters, this would also demonstrate the commitment of senior leadership. More importantly, successful collaboration and sharing initiatives should be rewarded both publicly and professionally.

**Recommendation 2.3:** *The Departments should jointly develop metrics (with indicated accountability) that measure health care outcomes related to access, quality, and cost as well as progress toward objectives for collaboration, sharing and desired outcomes. In the annual report recommended in Recommendation 1.1, the interagency leadership committee should include these results and discuss the coming year's goals.*

The American Legion strongly supports this “scorecard” management style. Accountability is key to the successful measure of desired outcomes. Again, senior leadership’s focus on collaboration and sharing initiatives will generate attention at every level.

### **Providing a Seamless Transition to Veteran Status**

**Recommendation 3.1:** *VA and DOD should develop and deploy by fiscal year 2005 electronic medical records that are interoperable, bi-directional, and standards-based.*

The American Legion fully supports this recommendation and recognizes the importance of electronic medical records, especially for veterans with service-connected disabled medical conditions. The electronic medical records should also be accessible for those in the Reserve components. A service member going from active-duty to the National Guard or Reserves should not close one set of medical records and open another set with no connectivity until collected and consolidated by VA.

Having access to a patient’s entire medical record is extremely important and helpful to health care professions, especially in large integrated health care systems like VA and DOD. In today’s military, a veteran may have several forms of medical records. It is not uncommon for a service member to become a military dependent upon discharge from active duty; however, seldom will the active-duty military medical record be consolidated with the military dependent’s medical record, because a military family member is filed under the active-duty service members social security number. This situation is further aggravated if the military family member enlists into the National Guard or Reserves, the military dependent’s medical record and prior service medical records are not consolidated with the Reserve component’s medical records. Electronic medical records should make consolidation easier.

When a veteran enrolls in VA for health care or files a disability claim, consolidating a veteran’s total military medical record is extremely important. The faster this consolidation occurs, the faster quality health care can be provided or a disability claim can be adjudicated.

**Recommendation 3.2:** *The Administration should direct HHS to declare the two Departments to be a single health care system for purposes of implementing HIPAA regulations.*

The American Legion supports this recommendation.

**Recommendation 3.3:** *The Departments should implement by fiscal year 2005 a mandatory single separation physical as a prerequisite of promptly completing the military separation process. Upon separation, DOD should transmit an electronic DD214 to VA.*

The American Legion supports a mandatory single separation physical and the transfer of an electronic DD Form 214 to VA. The mandatory single separation physical established an important health care baseline. This is extremely important, especially when dealing with medical conditions that may manifest over a period of time.

The DD Form 214 is the “passkey” to every VA benefit because it establishes eligibility of veteran’s status. Providing VA with an electronic version of the DD Form 214 will help ease the transition.

**Recommendation 3.4:** *VA and DOD should expand the one-stop shopping process to facilitate a more effective seamless transition to veteran status. This process would provide, at a minimum: 1) a standard discharge examination suitable to document conditions that might indicate a compensable condition; 2) full outreach; 3) claimant counseling; and 4) when appropriate, referral for a Compensation and Pension examination and follow-up claims adjudication and rating.*

Clearly, The American Legion and other veterans’ and military service organizations can play an important role in this effort. The American Legion and other veterans’ service organizations have well-trained service officers around the country to assist veterans, free of charge, in filing disability claims with VA and other claims assistance.

**Recommendation 3.5:** *VA and DOD should expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards experienced while serving in the Armed Forces; and to conduct epidemiological studies to understand the consequences of such events*

The American Legion supports this recommendation. Over the years, The American Legion has lobbied Congress, VA, and DOD on such exposure issues as Agent Orange, radiation, and Gulf War Illness. Each and every time, DOD’s and VA’s medical record-keeping shortfalls hampered timely access to quality health care and just compensation of service-connected medical disabilities.

**Recommendation 3.6:** *By fiscal year 2004, VA and DOD should initiate a process for routine sharing of each service member’s assignment history, location, occupational exposure, and injuries information.*

The American Legion supports this recommendation and believes this is not a technological, but rather a philosophical barrier. There appears to be a reluctance by DOD to fully cooperate with VA in providing much of this information, because of its sensitivity. The American Legion believes declassified information could be developed to meet this recommendation without compromising classified information. Exact locations can be vague, but the fact a veteran was within an area exposed to high levels of radiation or contamination. This information would provide valuable information to a claims adjudicator without revealing the veteran’s exact physical location, mission, or other classified data. With senior leadership’s focus and support, this recommendation is achievable.

**Recommendation 3.7:** *The Departments should: 1) add an ex officio member from VA to the Armed Forces Epidemiological Board and to the DOD Safety and Occupational Health Committee; 2) implement continuous health surveillance and research programs to identify the long-term health consequences of military service in high-risk occupations, settings, or events;*

and 3) jointly issue an annual report on Force Health Protection, and make it available to the public.

The American Legion supports this recommendation.

### **Removing Barriers to Collaboration**

**Recommendation 4.1:** *The Secretaries of Veterans Affairs and Defense should revise their health care organization structures in order to provide more effective and coordinated management of their individual health care systems, enhance overall health care outcomes, and improve the structural congruence between the two Departments.*

The American Legion agrees with this recommendation. Currently, VA has 21 Veterans Integrated Service Networks (VISNs), while TRICARE consists of three regions. The American Legion suggests VA reevaluate its current decentralized organizational structure and consider reducing the number of VISNs.

In addition, VA should also reevaluate the current Veterans Equitable Resource Allocation (VERA) formula for the distributions of annual appropriations. One area of great concern is the failure to account for all enrolled veterans rather than excluding Priority Groups 7 and 8, even if they are noncompensable, service-connected disabled veterans. If they are enrolled, then they are patients and should be treated as such in the consideration of fiscal distributions.

Another area of concern is ending VERA at the VISN level rather than the facility level. The distribution of resources is formula based to the VERA director – from that point on, it is purely subjective. The American Legion believes that the factors used in determining the VERA allocation to the VISN should also apply to the further distribution to the local medical facility.

Finally, all third-party reimbursements should be retained by the medical facility providing the service, not redistributed to other medical facilities within or outside the VISN.

**Recommendation 4.2:** *The Secretaries of Veterans Affairs and Defense, based on the recommendations of the interagency leadership committee, should provide significantly enhanced authority, accountability, and incentives to health care managers at the local and regional levels in order to enhance standardized and collaborative activities that improve health care delivery and control costs.*

The American Legion supports this recommendation.

**Recommendation 4.3:** *VA and DOD should integrate clinical pharmacy initiatives through the coordinated development of: 1) a national joint core formulary; and 2) a single, common clinical data screening tool by fiscal year 2005 that ensures reliable, electronic access to complete pharmaceutical profiles for VA/DOD dual users across both systems.*

The American Legion supports this recommendation and strongly encourages collaboration and sharing initiatives with all 7 VA Consolidated Mail Outpatient Pharmacies (CMOP) sites. In

fact, The American Legion advocates increasing the number of CMOP sites across the Nation should increased demands exceed the current ability to deliver prescriptions in a timely manner.

**Recommendation 4.4:** *VA and DOD should collaborate on policy and program changes, through local sharing arrangements, which would permit prescriptions written by either VA or MTF providers to be filled for dual users by the other Department's pharmacies.*

The American Legion supports this recommendation and would consider expanding this authority to any Federal health care provider, including Indian Health Services.

**Recommendation 4.5:** *VA and DOD should work with industry to establish a uniform methodology for medical supplies and equipment identification and standardization and to facilitate additional joint contracting initiatives. VA and DOD should identify opportunities for joint acquisitions in all areas of products and services.*

The American Legion supports this recommendation.

**Recommendation 4.6:** *The interagency leadership committee should identify those functional areas where the Departments have similar information requirements so that they can work together to reengineer business processes and information technology in order to enhance interoperability and efficiency.*

The American Legion fully advocates this recommendation.

**Recommendation 4.7:** *VA and DOD should implement facility lifecycles management practices on an enterprise-wide basis. This should be accomplished by aligning business rules, eliminating statutory barriers, and adopting best practices.*

The American Legion supports this recommendation.

**Recommendation 4.8:** *VA and DOD should declare that joint ventures are integral to the standard operations of both Departments. Through the interagency leadership committee, the Departments should articulate policy requiring that: 1) all major initiatives of each Department be designed and tested for effectiveness and suitability in joint venture sites; 2) lessons learned from successful joint ventures be shared with other joint venture sites and also throughout the health care delivery systems of the two Departments; and 3) all proposed VA and DOD facility construction within a geographic area be evaluated as a potential joint venture.*

The American Legion fully supports this recommendation, especially with renewed talks regarding another round of base closures. Before any future MTF is selected for closure, joint venture operations should be explored.

With increased dependence on Reserve components, VA and DOD should evaluate possible collaboration and sharing initiatives for meeting the health care needs of National Guard and Reserve personnel. Serious consideration should also be given to the establishment of more Reserve component billets for health care professionals.

**Recommendation 4.9:** *VA and DOD should work together to identify and address staffing shortfalls, develop consistent clinical scopes of practices for non-physician providers, and ensure that their provider credentialing systems interface with each other.*

The American Legion supports this recommendation with special emphasis being placed on recruiting, educating, credentialing and hiring recently separated active-duty service members, especially those with service-connected medical disabilities. Both agencies should also consider recruiting, educating, credentialing and hiring members of the National Guard and Reserve. Veterans make great employees because they are certifiably drug-free, possess a good work ethic, understand teamwork, are trainable to standards, and understand the military life style.

Another window-of-opportunity is the recruitment of health care specialists, faced with extremely high malpractice insurance premium, to join VA and DOD professional staff. Many highly qualified health care specialist, especially neurosurgeons, ob-gyns, emergency physicians, orthopedic surgeons, and general surgeons. For an example, the average annual cost of medical-liability premium for a neurosurgeon is approximately \$71,200, but in Chicago, it is \$283,000 and in Philadelphia, it is \$267,000. This represents a 35.6 percent increase from 2001 to 2002.

According to the American Medical Association, seven hospital obstetrics units have closed and six medical centers no longer perform mammographies, just in Florida. In Pennsylvania, over 900 doctors have either closed practices, limited their services, or left the state since 2001. In Nevada, more than 30 ob-gyns have closed their practices. In Tacoma, Washington, have of the ob-gyns won't deliver babies. This medical-malpractice crisis in 18 states (NY, CT, NJ, PA, WV, OH, KY, NC, GA, FL, IL, MO, AR, MS, TX, NV, OR, and WA) offers a unique opportunity for recruit by both VA and DOD for specialists.

### **Timely Access to Health Services and the Mismatch Between Demand and Funding**

The American Legion believes this is the most salient and challenging issue addressed by the PTF. Clearly, The American Legion strongly believes timely access to quality health care is a moral, ethical, and legal obligation of any health care delivery system. Preventive medicine has demonstrated its life-saving benefits, not to mention the economical impact as well.

For years, The American Legion watched the national rationing of VA health care through a complex and complicated maze of rules, regulations, and policies governing who would receive health care in what setting under which conditions. The American Legion advocated a dramatic shift from a hospital-based to a managed-care health care system. Finally, Congress stopped the madness with enactment of the Veterans' Health Care Eligibility Reform Act of 1996 (Public Law 104-262). The vision called for opening enrollment in VHA to any eligible veteran seeking access to quality health care, within existing appropriations. The idea was to receive co-payments and third-party reimbursements for the treatment of nonservice-connected medical conditions to help supplement VA's discretionary appropriations. Unfortunately, the largest single identified health insurance program (Medicare) is exempt from reimbursing VA for the treatment of Medicare-eligible veterans' nonservice-connected medical conditions.

Secondly, many private health insurance providers failed to recognize VA as a medical care provider and refused to reimburse VA for treating their policyholders. Others effectively

challenged VA's billing and collection practices, then denied payments. VA's Medical Care Collection Fund (MCCF) had far more excuses than solutions to their billing and collection process. In fact, their collection rate was well below acceptable industry standards. A major contributing factor was VA's inability to collect from Medicare. In order to collect from Medicare supplemental insurance providers, VA had to bill Medicare, as though VA could collect, to reflect the amount due from the supplemental insurers.

Although VA medical care receives discretionary appropriations, those appropriations are offset by the amount of third-party collections Congress determines achievable. VA's billing and collection process has improved dramatically in recent years; however, it will never realize its true potential until it can collect from its largest customer – the Centers for Medicare and Medicaid Services (CMS).

Medicare-eligibility is not a factor in determining eligibility to enroll in either VA, Indian Health Services, or DOD's TRICARE, yet TRICARE providers do receive Medicare reimbursements and DOD serves as the supplemental insurer. Indian Health Services is authorized to bill and collect from CMS for the treatment of both Medicare-eligible and Medicaid-eligible beneficiaries. Both health care systems receive annual discretionary appropriations, just like VA. All three health care systems have eligible criteria that do not mention eligibility in any CMS program.

**Recommendation 5.1:** *The Federal Government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal.*

The American Legion fully supports designating VA medical care as mandatory funding. The American Legion defines "full funding" or "guaranteed funding" as mandatory funding. Mandatory funding does not require any modifications to the current budget or appropriations process. The American Legion believes mandatory funding represents the ongoing cost of freedom.

**Recommendation 5.2:** *VA facilities should be held accountable to meet the VA's access standards for enrolled Priority Groups 1 through 7. In instances where an appointment cannot be offered within the access standards, VA should be required to arrange for care with a non-VA provider, unless the veteran elects to wait for an available appointment within VA.*

The American Legion fully supports this recommendation. The American Legion believes this is VA's moral, ethical, and legal obligation to its beneficiaries. No veteran should ever die, waiting for a medical appointment more than 30 days.

Since the PTF was tasked with "improving health care delivery between VA and DOD," The American Legion would strongly recommend that veterans be referred to TRICARE health care providers rather than non-VA providers as recommended in the **Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance** in 1999, as *Issue III.F – Increase VA use of DOD's TRICARE for Selected VA Medical Services*. Since many VA

enrollees are also TRICARE-eligible, this would enhance collaboration and sharing of scarce resources.

**Recommendation 5.3:** *The present uncertain access status and funding of Priority Group 8 veterans is unacceptable. Individual veterans have not known from year to year if they will be granted access to VA care. The President and Congress should work together to solve this problem.*

The American Legion adamantly opposes this recommendation and views it as absolutely unconscionable! Veterans are taught to leave nobody behind on the battlefield – The American Legion believes that this same philosophy should be carried into the VA health care system. Veterans are in this together – not as individuals.

Dissenting Commission Members to this recommendation – the only dissent in the entire report – offered suggestions based on allowing Priority Group 8 veterans to enroll and receive timely access to quality VA health care. While Recommendations 5.1 and 5.2 direct Congress to provide adequate funding to cover the cost of health care for Priority Groups 1 through 7, some Commission Members offered an alternative that allows Priority Group 8 veterans choose from one of three health benefits just like TRICARE:

- All enrolled Priority Group 8 veterans would be required to identify their public/private health insurers.

*This is similar to an initiative in the President's budget request for FY 2004.*

- VA would be authorized as a Medicare provider for Priority Group 8 veterans and be permitted to bill, collect and retain all or some defined portion of third-party reimbursements from CMS for the treatment of non-service-connected medical conditions.

*Just like participating private physicians are doing under TRICARE for Life.*

- VA should be authorized to offer a premium-based health insurance policy to any enrolled Priority Group 8 veteran with no public/private health insurance.

*Just like CMS does for Medicare.*

- All enrolled Priority Group 8 veterans would be required to make co-payments for the treatment of non-service connected medical conditions and prescriptions.

*Just like they are currently doing.*

- All enrolled Priority Group 8 veterans with no public/private health insurance would agree to make co-payments and pay reasonable charges for treatment of non-service connected medical conditions.

*Just like in the private sector.*

Mr. Chairman and Members of the Committee, the vast majority of the veterans' population falls into Priority Group 8, yet the majority of the PTF voted against providing a substantive recommendation regarding Priority Group 8 veterans' eligibility for VA health care. They even described Priority Group 8 veterans as "*those veterans without compensable service-connected conditions whose incomes are above a geographically-adjusted means test*" as though that makes them different from any other veteran. In reality, the only difference between some Priority Group 7 and Priority Group 8 is their zip code.

A veteran is a veteran. There are Priority Group 1 veterans that never left the shores of the United States, yet there are Priority Group 8 veterans that served in theaters of armed conflicts. How the majority of the PTF Commission could leave so many members of the "Greatest Generation," the "Forgotten War," Vietnam War, the Persian Gulf War, and Bosnia "standing on the doorsteps" of VA without a single recommendation is irresponsible and a tremendous disappointment to the veterans' community.

The recommendations of the dissenting Commission members are fiscally responsible and, if enacted, should be scored as budget neutral. If a private sector health care provider were to treat them for nonservice-connected medical conditions, the Priority Group 8 veterans would be asked to comply with these same guidelines offered in the dissenting remarks, so why should VA hold them to the same requirements for treatment?

By not making any recommendations for Priority Group 8, the PTF sends a message to all Priority Group 8 veterans – to be granted timely access to VA health care -- consider other alternatives to qualify:

- Become financially destitute and qualify as a Priority Group 5 veteran.
- Become catastrophically disabled and qualify as a Priority Group 4 veteran.
- Move to a compatible HUD geographically indexed area and qualify as a Priority Group 7 veteran.

These are veterans of the armed forces being denied enrollment and timely access to quality health care in the VA integrated health care network even if they have a means to pay for their medical treatment. Some how The American Legion does not believe this represents the "thanks of a grateful Nation."

In the military upon successful conclusion of a task, it is customary to say: "Mission complete!" Mr. Chairman and Members of the Committee, although the PTF has published a final report, their mission is incomplete – they left about 20 million veterans behind.

Thank you for the opportunity to participate in this hearing. That concludes my testimony. I welcome any questions.